STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155358	B. WING		08/30/2011
				ET ADDRESS, CITY, STATE, ZIP CODI	_
NAME OF I	PROVIDER OR SUPPLIE	R		O POPLAR ST	-
MEADON	NS MANOR CONV	ALESCENT & REHAB CENTER		RE HAUTE, IN47803	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	
PREFIX	· ·	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	ROPRIATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
		or the Investigation of	F0000	Please accept this Revi	
	Complaints IN00094248 and			Plan of Credible Allegat	!
	IN00095253.			compliance.Meadows Malways and will continue	
				comply with all State an	
	Complaint IN00	0094248 - Substantiated.		Regulations. This surve	!
	1 ^	related to the allegation		not reflect the actual car	
		related to the anegation		all residents of the facili	ty.
	are cited.				
	*	0095253 - Substantiated.			
	Federal/state de	ficiencies related to the			
	allegations are c	eited at F223, F225, F226,			
	F309, F315 and				
	,				
	Survey detect	August 25, 26, 29 and 30,			
	1	August 25, 20, 29 and 50,			
	2011				
	Facility number				
	Provider numbe	er: 155358			
	AIM number: 1	00267640			
	Survey team:				
	Kimberly Perigo	n RN			
		0, 1014			
	Census bed type	2.			
	SNF/NF: 71				
	Total: 71				
	Census payor ty	pe:			
	Medicare: 07	•			
	Medicaid: 50				
	Other: 14				
	Total: 71				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TGYQ11

Facility ID:

000249

TITLE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED			
AND PLAN	OF CORRECTION	155358	A. BUILDING		08/30/2011
		100000	B. WING	A DDDDCG COMM COATE THE CODE	00/00/2011
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
MEADOV	WS MANOR CONVA	ALESCENT & REHAB CENTER		E HAUTE, IN47803	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	Sample: 11				
	These deficiencie	es reflect state findings			
	cited in accordance with 410 IAC 16.2.				
F0223 SS=D	Quality review 9/07. The resident has t verbal, sexual, phy	/11 by Suzanne Williams, RN he right to be free from ysical, and mental abuse, ent, and involuntary			
	sexual, or physica punishment, or inv	oluntary seclusion.	F0000	Mandawa Manay Fast has	00/1/2/2011
		ews and record reviews,	F0223	Meadows Manor East has never nor would we ever	09/16/2011
	_	to ensure a resident had		knowingly hire anyone who h	nas
		nistreatment and/or abuse		been guilty or even accused	
	_	ion of staff to resident		any sort of abuse. All emplo	· I
	abuse reviewed i	n a sample of 11		receive a local and state crin	
	residents. (Reside	ent H)		check, all references checke and the State CNA Registry	· ·
	Findings include	:		checked to see if there are a allegations, and if the CNA is good standing with an active	ny s in
	Interview on Aug	gust 25, 2011 at 3:25		certification. All these check	I
	p.m.; with RN #3	3 indicated a known		were done on CNA #4. Also employees are given a copy	
	•	ad occurred on the night	1	the abuse policy and resider	l l
		late] and involved		rights in orientation before th	
	Resident H and C	-	1	are allowed on the floor to w	l l
				This CNA was a new employ	I
	Interview on Aug	gust 26, 2011 at 2:30		two days and was told to lea the facility on the day of the	ve
	,	indicated a known		incident, with termination the	next
	-	ad occurred on the night		day by the D.O.N. He had n	o
		3, 2011; which involved		contact with resident H after	I
	_	CNA #4. The incident		occurrance. As CNA #6 said	I
	Tesident II und C			survey, "resident H did not you did not indicate being hurt, n	I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DDIC	00	COMPL	ETED
		155358	A. BUII B. WIN			08/30/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R		1	OPLAR ST		
MEADO	WS MANOD CONV	ALESCENT & REHAB CENTER		1	HAUTE, IN47803		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	<u> </u>	R LSC IDENTIFYING INFORMATION)	+	TAG	·	. 4 -	DATE
	1	y CNA #6 and reported to			she see any change of color resident H's hands." An inci		
	RN #7. RN #5 1	further indicated CNA #4			report was done, which follo		
	had been sent home during the shift and				the resident's condition for		
	later terminated.				seventy-two hours after the		
					incident. There was no		
	On August 29. 2	011, the Director of			complications for this reside		
	Nursing provided a copy of an Incident				prevent a reoccurrance of the		
	1 .	gust 03, 2011 at 4:30 a.m.			F-tag, an inservice on abuse held on 9-15-11 (see attache		
	Topon dated Au	.5 ил т.эо или.			#1). This, as well as all the		
	A statement provided by CNA #6 to the				mentioned steps, will prever		
					resident H, and all present of		
		indicated; "On 8-3-11			future residents from having		
	1	CNA #4's name] and I			reoccurrance.Monitored by:		
	went into get [R	esident H's name]			Administrator, D.O.N., Inser	vice	
	dressed. We tur	ned him to me first and			Director, and Q.A.		
	[CNA #4's name	e] washed his bottom and			Committee***REVISIONAdr ator was notified of this incide		
	put the brief und	ler him, then we turned			a timely manner, however, f		
	1 ^	l's name]. [Resident H's			to notate this in the Plan of		
	1 -	the h you doin. I said			Correction. All allegations of	f	
	1 -	ou dressed he started			abuse are investigated		
	1				thoroughly, and brought to the		
	1	#4's name]. [CNA #4's			monthly Q.A. Meeting. Social		
	1 2	nis fist and started			Services will do random wee random checks and if any	екіу	
		Resident H's name] hands			questionable allegations she	will	
		er. I said you need to			report immediately to		
	walk away. [CN	NA #4's name] turned and			Administrator all residents		
	hit the wall and	started growling and I			interviewed willl be brought	to the	
	said you need to	go answer [other			next morning meetings.		
	resident's name	light. He walked out and			Monitored by: Administrator		
	_	g [Resident H's name]			D.O.N. Social Services, and Committee	Q. A.	
	dressed with no				Johnnie		
	aressea with no	problem. [ole]					
	CNA #6 was int	erviewed on August 29,					
		•					
	1	n. During the interview					
	1	ed her statement was					
	correct. CNA #6	6 had indicated, after					

000249

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155358	B. WIN			08/30/2	011
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	KOVIDEK OK SOLI EIEK			1	OPLAR ST		
MEADO	WS MANOR CONVA	ALESCENT & REHAB CENTER		TERRE	HAUTE, IN47803		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		H was observed to be					
	• •	hands while being					
	_	ent H did not yell, did not					
		ort, nor did she see any					
	change of color t	o Resident H's hands.					
	After having con	npleted Resident H's care,					
	CNA #6 left the	room and reported the					
	observed inciden	t to RN #7.					
	A statement prov	rided by RN #7 to the					
	nursing facility in	ndicated; "8-3-11 At					
	about approx 4:3	0 AM I was in the					
	hallway on West	Wing and [CNA #6's					
	1	my name She told me					
	1	oroblem with [CNA # 4's					
	1	CNA #6's name] stated					
	1 2	d [CNA #4's name] were					
		are for a resident, she					
	l ^	#4's name] putting his					
	-	esident's hands which					
		and [CNA #4's name]					
		the resident's hands. [CNA					
	1 .	CNA #4's name] to step					
		sident and she would					
	1	im. [CNA #4's name]					
		the wall with his fist and					
	**						
	1 -	nst the wall. [CNA #6's					
	_	nim he needed to leave					
		times. [CNA #4's name]					
	I =	NA #6's name] came to					
	_	4's name] was at the					
		hile [CNA #6's name]					
	and I talked. [sic]]"					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	(X2) MULTIPLE CONSTRUCTION A DULL DIVIC 00			(X3) DATE SURVEY COMPLETED	
THID I LITTLE	or connection	155358	A. BUII			08/30/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R			OPLAR ST		
MEADO	WS MANOR CONV	ALESCENT & REHAB CENTER		1	HAUTE, IN47803		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	1	vided by RN #7 to the					
	1 .	indicated; "8-3-11 At					
	1 ^ ^	I I approached [CNA #4's					
	_	ing Nurses Station and					
		to talk with him, that I					
		s upset I asked [CNA					
		he was upset about and					
		ng AM care the resident					
		his foot. I asked [CNA					
	#4's name] if he was holding the residents						
	hands and he replied that he was holding						
		vas reported that he was					
		sident's hands. He replied					
	1	use when he get hit in the					
		'trigger point,' that the last					
		n the face he kept control					
		walk out of the room. I					
	1	has happened before?'					
		I observed [CNA #4's					
		and unclenching his fist,					
		to the side and profuse					
	_	ne was talking with me. I					
	_ ~	s name] if he had hit the					
		t and he replied 'No.' I					
		reported that he did. He					
	_	nay have put his hand					
	I -	harder than he intended. I					
	_	name] that regulations					
		s that he will have to clock					
	out [sic]"						
	CNA #4's person	nnel records were					
	1 ^	gust 29, 2011 at 1:50 p.m.					
	1	ermination Notification					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155358			(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/30/2011
	PROVIDER OR SUPPLIER	ALESCENT & REHAB CENTER	3300 PG	ADDRESS, CITY, STATE, ZIP CODE OPLAR ST HAUTE, IN47803	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	Director of Nursi "Resident Abuse Holding and sque while giving AD living] care and v room, hit the wal on the way out th that held resident Stated 'when I ge my trigger point. The Director of on August 29, 20 the interview, the indicated CNA # resident abuse.	8/3/11. Summary: eezing resident's hands L [activities of daily when asked to leave the l with fist and growled he door. Told Supervisor his hand and hit wall hard. ht hit in my face that is			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII I	NN/C	00	COMPL	ETED
		155358	A. BUILI			08/30/2	011
			B. WING		DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER	L.					
MEADON	NE MANOD CONV	ALESCENT & REHAB CENTER			OPLAR ST HAUTE, IN47803		
IVIEADOV	VS WANOR CONVA	ALESCENT & REHAB CENTER		IERRE	HAUTE, IN47803		_
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0225		ot employ individuals who					
SS=D		guilty of abusing, neglecting,					
		dents by a court of law; or					
have had a finding entered into the State							
	nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation						
		and report any knowledge it					
		a court of law against an					
employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged							
	,	g mistreatment, neglect, or					
		njuries of unknown source					
		ion of resident property are					
		tely to the administrator of					
		other officials in accordance					
		ough established procedures					
	(including to the S	tate survey and certification					
	agency).						
	,	ave evidence that all					
		are thoroughly investigated, further potential abuse while					
	the investigation is	•					
	uic investigation is	s in progress.					
	The results of all in	nvestigations must be					
		ministrator or his designated					
		d to other officials in					
	accordance with S	State law (including to the					
		certification agency) within 5					
	• •	e incident, and if the alleged					
		d appropriate corrective	1				
	action must be tak		F02		CNA #4 received all criminal	1	00/16/2011
		ews and record reviews,	F02	.25	checks, reference checks, a		09/16/2011
		I to ensure an observed			was checked on the State CNA		
	incident of reside	ent mistreatment was			Registry. There was no indicat		
immediately reported and the facility and			anywhere that this employee was				
		prevention of further			capable or had done this		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155358	B. WIN			08/30/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			OPLAR ST		
MEADO\	NS MANOR CONV	ALESCENT & REHAB CENTER		1	HAUTE, IN47803		
					17.012, 1117000		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	1 ^	tment and/or abuse by			allegation in the past. Meado Manor would not have hired		
	not having immediately removed the				or anyone else if these check		
	identified staff, f	for 1 of 1 allegation of			were not completely without		
	staff to resident	abuse reviewed in a			allegations. We also give an		
	sample of 11 res	idents. (Resident H)			Abuse, and Resident Rights		
					policy to every new hire befo		
	Findings include	··			they are allowed to work on t		
	Tilldings illerade	·•			floor. They are also given th		
		. 25 2011 2 25			policy on how to report any s		
		gust 25, 2011 at 3:25			or suspicious activity/behavion a staff member (see attached		
		3 indicated a known			#1). CNA #6 did tell CNA #4		
	incident which h	ad occurred on the night			leave the room, but failed to		
	shift [unknown o	late] and involved			immediately to her superviso		
	Resident H and	CNA #4.			She continued with her resid		
					CNA #6 did receive a verbal		
	Interview on Au	gust 26, 2011 at 2:30			warning for this offense. (se		
		5 indicated a known			attached #2). RN #7 also fail	ed to	
	· ·				follow procedure, which is to		
		ad occurred on the night			escort the accused employed of the facility immediately. S		
	_	3, 2011; which involved			called the D.O.N. to advise h		
	Resident H and	CNA #4. The incident			the incident, instead of follow		
	was witnessed by	y CNA #6 and reported to			procedure, and then notifying	-	
	RN #7. RN #5 f	further indicated CNA #4			D.O.N. RN #7 was the previ	ous	
	had been sent ho	ome during the shift and			D.O.N., so she knew the poli		
		and that RN #7 was also			well. She had to have others		
	no longer emplo				home pending investigation of		
	l no longer emplo	yeu.			previous occasions. Employ #4 was escorted out, but not		
	0 4	011 the Director of			immediately. He was terminate		
	1	011, the Director of			the next day. Because of he		
	1 .	d a copy of an Incident			knowledge and number of ye		
	Report dated August 03, 2011 at 4:30 a.m.				working not only as the DON		
					a floor supervisor and charge		
	A statement prov	vided by CNA #6 to the			nurse in the facility, she rece		
	nursing facility indicated; "On 8-3-11				a written warning and susper		
	about 4:30 am[CNA #4's name] and I				(see attached #3). To preven		
	-	esident H's name]			resident H, as well as preser future residents from having		
		ned him to me first and			F-tag reoccur, an inservice w		
	i uresseu. We tun	neu min to me mist and	1				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155358	(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE: COMPL 08/30/2	ETED
	PROVIDER OR SUPPLIER	L R ALESCENT & REHAB CENTER	1	STREET A	DPLAR ST HAUTE, IN47803	ı	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	put the brief und him to [CNA #4 name] said what we are getting yo punching [CNA name] grabbed h squezzing [sic] [harder and harder walk away. [CN hit the wall and said you need to resident's name] I finished getting dressed with no CNA #6 was into 2011 at 1:34 p.m. CNA #6 indicate correct. CNA #6 asked, Resident trying to free his squeezed. Residindicate being he change of color After having correct. CNA #6 left the observed incider. A statement proving facility in about approx 4:3 hallway on West	erviewed on August 29, a. During the interview and her statement was be had indicated, after H was observed to be hands while being lent H did not yell, did not art, nor did she see any to Resident H's hands. Inpleted Resident H's care, room and reported the			held on 9-15-11 (see attache #1). Monitored by: Administr D.O.N., Inservice Director, a Q.A. Committee.***REVISIONAdirator was notified of incident per faciliy policy. Abuse policible been reviewed and will contito be reviewed every 6 montand revised as needed. Administrator was notified of incident in a timely manner, failed to include this in the P Correction. Administrator ar D.O.N will ask reporting staff member if the alleged staff member has been escorted the building. All allegations of abuse are investigated thoroughly, and reported to a state authorities as required. Monitored by: Administrator D.O.N., Inservice Director, a Q.A. Committee	ator, nd minist as cy has nued hs this but lan of from of	

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155358	A. BUII	LDING	00	COMPL 08/30/2	
		155556	B. WIN			06/30/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MEADON		ALESCENT & REHAB CENTER			OPLAR ST HAUTE, IN47803		
					HAUTE, IN47603		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	, i	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
IAG		problem with [CNA # 4's		IAG	,		DATE
	1	CNA #6's name] stated					
		-					
	that while she and [CNA #4's name] were providing AM care for a resident, she						
		#4's name] putting his					
	~	esident's hands which					
		and [CNA #4's name]					
	1	the resident's hands. [CNA					
		CNA #4's name] to step					
		sident and she would					
	*	im. [CNA #4's name]					
		the wall with his fist and					
	1	nst the wall. [CNA #6's					
	^	nim he needed to leave					
	1 1						
		times. [CNA #4's name]					
	_	NA #6's name] came to					
	_	4's name] was at the					
		rhile [CNA #6's name]					
	and I talked. [sic]	J					
	A statement prov	rided by RN #7 to the					
		ndicated; "8-3-11 At					
	"	I I approached [CNA #4's					
	_ ^ ^	ing Nurses Station and					
		o talk with him, that I					
		s upset I asked [CNA					
		he was upset about and					
	I =	ng AM care the resident					
		his foot. I asked [CNA					
		was holding the residents					
	_	lied that he was holding					
	_	as reported that he was					
		sident's hands. He replied					
		_					
	mai ne was becat	use when he get hit in the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155358	A. BUII	LDING	00	08/30/2	
		133330	B. WIN			00/30/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MEADOV	NS MANOR CONVA	ALESCENT & REHAB CENTER		1	OPLAR ST HAUTE, IN47803		
					11A01E, 1147000		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	DATE
		trigger point,' that the last		0			5.112
		n the face he kept control					
		•					
	and was able to walk out of the room. I asked, 'then this has happened before?'						
		observed [CNA #4's					
		and unclenching his fist,					
	1 2	to the side and profuse					
	1	e was talking with me. I					
	T	_					
	asked [CNA #4's name] if he had hit the						
	wall with his fist and he replied 'No.' I told him it was reported that he did. He						
		ay have put his hand					
	_	-					
	_	narder than he intended. I					
	_	name] that regulations					
		that he will have to clock					
	out [sic]"						
	A second statems	ont marrided by CNA #6					
		ent provided by CNA #6					
	1	cility indicated, "It took mins. to get [Resident H's					
		• .					
	_	use he was calmer when					
	-	walk out He took the					
		to the soiled room I					
	l -	ame] to leave about 4:20					
		:30 told the supervisor					
	about 4:40. [sic]'	,					
	CNIA #41a 4:	ecord indicated on the					
	-	ist 03, 2011 he clocked					
		nursing facility at 5:06					
	a.m.						
	CNIA IIAI	1					
	CNA #4's person						
	reviewed on Aug	ust 29, 2011 at 1:50 p.m.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155358		(X2) MU A. BUII		NSTRUCTION 00	(X3) DATE S COMPL	ETED	
		100000	B. WIN		PPPEG OWN OF THE THE	08/30/2	JII
NAME OF F	PROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE OPLAR ST		
MEADOV	VS MANOR CONVA	ALESCENT & REHAB CENTER			HAUTE, IN47803		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	OSS-REFERENCED TO THE APPROPRIATE	
1710		rmination Notification		1110			DATE
	1 2	2011; and signed by the					
	Director of Nursi						
		8/3/11. Summary:					
		eezing resident's hands					
		L [activities of daily					
		when asked to leave the					
		l with fist and growled					
	on the way out th	ne door. Told Supervisor					
	that held resident	's hand and hit wall hard.					
	Stated 'when I ge	t hit in my face that is					
	my trigger point.' "						
	The Director of N	Nursing was interviewed					
	on August 29, 20	11 at 2:15 p.m. During					
	the interview, the	e Director of Nursing					
	indicated CNA #4	4 was terminated, due to					
		The Director of Nursing					
		6 did not immediately					
	-	ation, and RN #7 did not					
	_	ove CNA #4 from the					
	• •	nt further potential					
	abuse.						
	This deficiency is IN00095253.	s related to Complaint					
	2 1 29(a)						
	3.1-28(c)						
F0226 SS=D	written policies and mistreatment, negl	evelop and implement d procedures that prohibit lect, and abuse of residents ion of resident property.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COM			COMPL	ETED
		155358	B. WIN			08/30/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		l	OPLAR ST		
MEADO\	WS MANOR CONV	ALESCENT & REHAB CENTER		1	HAUTE, IN47803		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
		ews and record reviews,	F0	226	Meadows East has and follow		09/16/2011
	the facility failed	d to ensure an allegation			it's abuse/neglect policy. Thi occurred because two emplo		
	of resident mistr	eatment was			did not follow the policy in a f	•	
	immeditately rep	ported and the identifed			manner. CNA #6 did follow	iiiioiy	
		een immediately removed			procedure in telling CNA #4 t	o	
	1 ^ -	er resident mistreatment,			leave the room, but finished	with	
	according to the	, , , , , , , , , , , , , , , , , , ,			her resident before reporting		
	1	•			her supervisor. RN #7 called		
		y and procedures, for 1 of			D.O.N. before removing CNA		
	1 allegation of staff to resident abuse				from the facility. As stated by surveyor's statement, RN #7		
	reviewed in a sai	mple of 11. (Resident H)			quoted the policy to CNA #4.		
					proves there is a policy in pla		
	Findings include	:			and the staff knows it. Also,		
					surveyor said the D.O.N.		
	Interview on Au	gust 25, 2011 at 3:25			presented her with the policy		
	p.m.; with RN #	3 indicated a known			Both of these employees we		
	incident which h	ad occurred on the night			reprimanded for their actions attached #'s 2 & 3). To preven		
		date] and involved			reoccurrance of this F-tag, a		
	Resident H and	-			inservice on reporting any		
	Trestaeth 11 and				allegations of abuse was held	d on	
	Interview on Au	augt 26, 2011 at 2:20			9-15-11 (see attached #1). T	his	
		gust 26, 2011 at 2:30			will ensure that resident H, a		
	· ·	5 indicated a known			other residents will not have	a	
		ad occurred on the night			delay in reporting again.		
		3, 2011; which involved			Monitored by: Administrator, D.O.N., Inservice Director, a		
	Resident H and	CNA #4. The incident			Q.A.	IG	
	was witnessed by	y CNA #6 and reported to			Committee***REVISIONAdm	inistr	
	RN #7. RN #5 f	Further indicated CNA #4			ator and D.O.N. will inquire a		
	had been sent ho	ome during the shift and			time of notification if alleged		
		and that RN #7 was also			employee has been escorted	I	
	no longer emplo				from the building. Also	ı	
	ino ionger emplo	<i>y</i> 00.			Administrator and D.O.N. wil interview or get statements fi		
	On August 20, 2	011 the Director of			all persons involved to ensur		
	1	011, the Director of			procedures were followed	-	
	J	d a copy of an Incident			correctly. Any allegations will	be	
	Report dated Au	gust 03, 2011 at 4:30 a.m.			reviewed within 24 hours to		
					ensure procedure was		

000249

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI A. BUII		NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155358	B. WING 08/30/2011			
	PROVIDER OR SUPPLIER	LESCENT & REHAB CENTER	1	3300 PC	DDRESS, CITY, STATE, ZIP CODE DPLAR ST HAUTE, IN47803	
	SUMMARY S' (EACH DEFICIENCE REGULATORY OR A statement provoursing facility in about 4:30 am[C] went into get [Reduressed. We turn [CNA #4's name] put the brief under him to [CNA #4'name] said what we are getting you punching [CNA #4'name] grabbed his squezzing [sic] [I harder and harder walk away. [CN hit the wall and seaid you need to resident's name] I finished getting dressed with no put the squezed with no put the walk away. [CN hit the wall and seaid you need to resident's name] I finished getting dressed with no put the squezed with no put the squezed with the wall and seaid you need to resident's name] I finished getting dressed with no put the squezed with no pu	ALESCENT & REHAB CENTER TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ided by CNA #6 to the idicated; "On 8-3-11 NA #4's name] and I sident H's name] ided him to me first and washed his bottom and er him, then we turned s name]. [Resident H's the h you doin. I said ou dressed he started #4's name]. [CNA #4's is fist and started Resident H's name] hands r. I said you need to A #4's name] turned and tarted growling and I go answer [other light. He walked out and [Resident H's name] broblem. [sic]" reviewed on August 29, During the interview d her statement was had indicated, after H was observed to be hands while being ent H did not yell, did not art, nor did she see any	B. WIN	STREET A	PLAR ST	(X5) COMPLETION DATE n es dent rther
	After having con	o Resident H's hands. upleted Resident H's care, room and reported the t to RN #7.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155358		(X2) MI A. BUII B. WIN	LDING	nstruction 00	(X3) DATE S COMPL 08/30/2	ETED	
NAME OF I			D. WIN		DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	(3300 PC	OPLAR ST		
MEADOV	MEADOWS MANOR CONVALESCENT & REHAB CENTER			TERRE	HAUTE, IN47803		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC 1)		DATE
		vided by RN #7 to the					
	nursing facility indicated; "8-3-11 At about approx 4:30 AM I was in the						
		Wing and [CNA #6's					
	· ·	my name She told me					
	_ *	problem with [CNA # 4's					
	l .	CNA #6's name] stated					
	"	id [CNA #4's name] were					
	providing AM care for a resident, she						
	observed [CNA #4's name] putting his						
	hands over the resident's hands which						
	were doubled up and [CNA #4's name]						
	was squeezing the resident's hands. [CNA						
į	#6's name] told [CNA #4's name] to step					
	away from the re	esident and she would					
	finish dressing h	im. [CNA #4's name]					
	1	the wall with his fist and					
		inst the wall. [CNA #6's					
	I -	him he needed to leave					
		times. [CNA #4's name]					
	1	NA #6's name] came to					
	· ·	#4's name] was at the					
		while [CNA #6's name]					
	and I talked. [sic]"					
	Δ statement prov	vided by RN #7 to the					
	1	ndicated; "8-3-11 At					
		I I approached [CNA #4's					
		ing Nurses Station and					
		o talk with him, that I					
		s upset I asked [CNA					
		he was upset about and					
	1	ng AM care the resident					
		his foot. I asked [CNA					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TGYQ11 Facility ID: 000249

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED	
		155358	B. WIN			08/30/2	011	
NAME OF F	DROLUDED OD GUDDU IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u>I</u>		
NAME OF F	PROVIDER OR SUPPLIER			3300 P	OPLAR ST			
MEADOWS MANOR CONVALESCENT & REHAB CENTER		_	TERRE	HAUTE, IN47803				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX			COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		-	TAG	DEFICIENCI)		DATE	
	#4's name] if he was holding the residents							
	_	lied that he was holding						
		as reported that he was						
		sident's hands. He replied						
		use when he get hit in the						
	face that it's his 't	trigger point,' that the last						
	time he was hit in	n the face he kept control						
	and was able to v	valk out of the room. I						
	asked, 'then this l	has happened before?'						
	He replied yes. I	observed [CNA #4's						
	name] clenching	and unclenching his fist,						
		to the side and profuse						
		e was talking with me. I						
	I -	name] if he had hit the						
	_	and he replied 'No.' I						
		eported that he did. He						
		ay have put his hand						
	_	narder than he intended. I						
	~							
	_	name] that regulations						
		that he will have to clock						
	out [sic]"							
	A second statems	ent provided by CNA #6						
		cility indicated, "It took						
		•						
		nins. to get [Resident H's						
	_	use he was calmer when						
	-	walk out He took the						
		to the soiled room I						
	I -	ame] to leave about 4:20						
		:30 told the supervisor						
	about 4:40. [sic]'	'						
	CNA #4's time re	ecord indicated on the						
		ist 03, 2011 he clocked						
	morning of Augu	ist 05, 2011 He clocked						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

TGYQ11 Facility ID:

000249

If continuation sheet

Page 16 of 27

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155358	B. WIN			08/30/2	011
NAME OF F	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SOLI EIER			1	OPLAR ST		
MEADOWS MANOR CONVALESCENT & REHAB CENTER				TERRE	HAUTE, IN47803		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	out to leave the nursing facility at 5:06						
	a.m.						
	CDIA IIAI	1 1					
	CNA #4's person						
		gust 29, 2011 at 1:50 p.m.					
	1 2	rmination Notification					
		2011; and signed by the					
		ing had indicated					
		8/3/11. Summary:					
	Holding and squeezing resident's hands while giving ADL [activities of daily						
		when asked to leave the					
		ll with fist and growled					
		ne door. Told Supervisor					
		t's hand and hit wall hard.					
		et hit in my face that is					
	my trigger point.	! "!					
	TID: (C)	.T					
		Nursing was interviewed					
		011 at 2:15 p.m. During					
		e Director of Nursing					
		4 was terminated, due to					
	resident abuse.						
	 On August 29 - 20	011, the Director of					
		d a copy of the nursing					
	• •	Prevention Program					
		cedures [non-dated]					
		"Policy Statement: It is					
	· · · · · · · · · · · · · · · · · · ·	of our employees, to					
		any incident or suspected					
		ident abuse Our					
		condone resident abuse by					
	-	_					
	anyone, menuan	g staff members Abuse					

	X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING A. BUILDING A. BUILDING	COMPLETED 08/30/2011	
B. WING	00/30/2011	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
MEADOWS MANOR CONVALESCENT & REHAB CENTER TERRE HAUTE, IN47803		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (FACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION)	E COMPLETION DATE	
	DATE	
is defined as the willful inflicion of injury;		
unreasonable confinement; intimidation;		
punishment with resulting physical harm,		
pain or mental anguish Any individual		
observing an incident of resident abuse or		
suspecting resident abuse must promptly		
report such incident to a member of the		
nursing staff or to management"		
The Director of Nursing was interviewed		
on August 29, 2011 at 2:15 p.m. During		
the inteview, the Director of Nursing		
indicated their Abuse Prevention Program		
Policies and Procedures had not been		
followed for the incident dated August 03,		
2011 at 4:30 a.m. C.N.A #6 received		
written discipline due to not having		
immediately reported her observation.		
RN #7 received two days suspension due		
to not having immediately removed CNA		
#4 from the building to ensure prevention		
of any further abuse.		
This deficiency is related to Complaint		
IN00095253.		
3.1-28(a)		
F0309 Each resident must receive and the facility		
SS=D must provide the necessary care and services		
to attain or maintain the highest practicable		
physical, mental, and psychosocial well-being, in accordance with the comprehensive		
assessment and plan of care.		
Based on interviews and record reviews, F0309 Resident B did receive an ord	der 09/16/2011	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155358		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE: COMPL 08/30/2	ETED	
	PROVIDER OR SUPPLIER	L ALESCENT & REHAB CENTER	p. wiiv	STREET A	DDRESS, CITY, STATE, ZIP CODE DPLAR ST HAUTE, IN47803	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	the facility failed implementation of diagnosed with a (Resident B) for with a fungal inframple of 11 resembles ample of 11 resembles Findings included Resident B's climate reviewed on Auguann. Physician's Follod dated August 04 diagnosis of Funding faction. Physician's Order at 6:00 p.m. indicture B) Fungub - Apply on a twice daily for 1. A form, located clinical record, which is a form of the following faction of the following faction of the facti	It to ensure prompt of care for a resident if fungal toenail infection I of I resident reviewed fection of a toenail in the idents. Example 1 in the idents idents in the idents idents idents in the idents idents idents idents idents. Example 2 identification in the idents identification			on August 4, 2011, and it was faxed to pharmacy by nursing that time. On 8-5-11, pharmacy back to the facility for clarification. This fax was not seen by nursing until 8-8-11 physician was called at this for clarification. From 8-9-13-15-11, nursing staff called to get clarification, and left messages, but they failed to document this. On 8-16-11, pharmacy called again to get clarification. They waited elect days to notify facility they stididn't have it. On 8-22-11, the Doctor's Office was called two before finally receiving clarification. Pharmacy was notified that day, but had to order Vicks Vapo Rub and treatment started on Reside toenail at this time. There we consequences to resident did delay. The facility policy was followed on clarifications of physician orders. To prevent ensure that resident B, and another residents receive orde at timely basis an inservice wheld on 8-15-11 on tracking medication orders (see attack #4 & 5). Monitored by: D.O. A.D.O.N., Administrator and Committee***REVISIONMedication orders will be monitored by A.D.O.N. to ensure follow done timely for all orders. A.D.O.N. will report any order to ensure completed to Administration and D.O.N. in morning meet to ensure completion. All	g at acy a tacy a tack at tack and all ars on a tack and	

155358 B. WING 08/30/	PLETED 2011
NAME OF PROVIDER OR SUPPLIER MEADOWS MANOR CONVALESCENT & REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 3300 POPLAR ST TERRE HAUTE, IN47803	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY	(X5) COMPLETION DATE
pharmacy had requested the clarification because the orders, as written were unclear. Documentation dated August 22, 2011 [time not documented] indicated the Physician's orders dated August 04, 2011; had been clarified and the prescribed medications had been delivered to the nursing facility. Medication Administration Records dated August 01, 2011 through August 31, 2011; indicated Resident B had received the initial treatment of Fungnail Tincture, Fungi-nail, and Vicks Vapor Rub on August 23, 2011; during the 6:00 a.m. to 2:00 p.m. shift. The facility's Policy and Procedure for Physician Orders [non-dated] provided by the Director of Nursing on August 30, 2011 indicated; "Purpose: To ensure all physician orders are initiated and followed through. Procedure: 1. A duplicate copy of all new physician orders obtained during each shift will be attached to the 24 hour report sheet 4. If there is no call back for clarifications the initial nurse to inform oncoming shift to follow up with call to doctor and if still no return calls notify	DAIE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR COMPLETE					
ANDILAN	or correction	155358	A. BUILDING	ì		08/30/20	
			B. WING	PEET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				OPLAR ST		
MEADOV	VS MANOR CONVA	ALESCENT & REHAB CENTER			HAUTE, IN47803		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF	- 1	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		· · · · · · · · · · · · · · · · · · ·	TAC	j	DEFICIENCY)		DATE
		ursing, and/or Assistant					
		ng. The Medical					
	•	r of Nursing, and/or					
		or of Nursing will be					
		urn call with in 24 hours.					
		sheets will be obtained					
	_	tive nurse after morning					
	•	wed for accuracy and					
	follow up as need	led.					
	_	gust 25, 2011 at 2:15					
	p.m.; the Director of Nursing indicated						
	she had not receive	ved the pharmacy's					
	request for clarifi	ication. A medication					
	clarification shou	ıld have been done					
	with-in 24 hours;	to initiate prompt					
	treatment for the	diagnosed Fungi toenail.					
	This deficiency is IN00095253.	s related to Complaint					
	3/1-37(a)						
F0315 SS=D	assessment, the faresident who enter indwelling catheter the resident's clinic that catheterization resident who is incappropriate treatm urinary tract infectinormal bladder fur Based on intervise	ews and record reviews,	F0315		An order for a UA/C & S for resident E was received on		09/16/2011
	the facility failed	to ensure prompt			8-1-11. Urine sample was		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155358 08/30/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3300 POPLAR ST MEADOWS MANOR CONVALESCENT & REHAB CENTER TERRE HAUTE, IN47803 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE collected at 5:30 on 8-2-11. The treatment of a diagnosed urinary tract U/A results testing was faxed to infection for 1 of 3 residents reviewed for the physician on the same day at appropriate care and services of bladder 15:21 (3:21 pm). On 8-3-11, C & function in a sample of 11 residents. S results were faxed, scant growth observed, culture (Resident E) re-incubated. On 8-4-11, C & S results were received from Med Findings include: Lab. The night shift nurse did not pass it on that they were 1. Resident E's clinical records were received. Instead, she charted not received, and there was "no reviewed on August 25, 2011 at 2:30 p.m. odor, temperature of 97.6, and denies pain." This was charted Physician's orders dated August 01, 2011 on 8-3-11, 8-4-11, & 8-5-11 (see at 9:30 a.m.; indicated for staff to obtain a attached #6). The night shift supervisor, RN #7, was the urinalysis [a laboratory test for analysis of previous D.O.N., and definately urine] with culture and sensitivity knew the policy on reporting [susceptibility and/or resistance to unreturned labs to the D.O.N. antibiotics of identified microorganisms], She had received a written write-up and suspension for not due to a possible diagnosis of an urinary following an abuse policy earlier tract infection. that month. Resident E had no signs and symptoms of pain or Nurse's Notes indicated; "8-2-11 0530 discomfort during this time. (see attached #'s 6 & 7). On 8-8-11, [5:30 a.m.] UA [urinalysis] and C&S the day shift nurse who had been [culture and sensitivity] obtained @ this off returned and noticed we didn't time. ..." have lab results, and immediately called the lab for results (see attached #7). Labs were faxed to A Microbiology and Molecular Testing the facility at 10:00 on the same report dated August 05, 2011 indicated; day and faxed to physician when "Source: Urine. Collected: 08/02/11 received for orders. Physician did 05:30. Received: 08/02/11 15:21 [3:21 not return a call to the facility until 8-11-11 with orders. The resident p.m.]. Urine with Colony Count Culture still not complaining of pain at this Isolate: 01 Escherichia coli 100,000 time (see attached #7). The CFU/mL [volume of identified bacteria in facility policy on reporting of labs urine]. A list of antibiotics the identified to the physician was not followed by these few nurses. It is not the bacteria is resistant to, was printed on the

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DDIC	00	COMPL	LETED
		155358	A. BUII			08/30/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	L.		1			
MEVDOV	NS MANOD CONV	N ESCENT & DEHAD CENTED		1	OPLAR ST HAUTE, IN47803		
MEADOWS MANOR CONVALESCENT & REHAB CENTER				117012, 1147 003			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	report.				normal function of this facility ensure resident E and all	/. IO	
					residents of Meadows East		
	Continued review	w of Nurse's Notes			receive timely orders on labs	:	
	indicated on Aug	gust 11, 2011 [time not			an inservice was held on 9-1		
	documented] Res	sident E's attending			(see attached #'s 4 & 5). Th	е	
	1	ceived the Microbiology			D.O.N. also will continue to t	rack	
	* *	esting report dated			all labs on timeliness of		
	August 04, 2011	• .			results.Monitored by:	\ NI	
	August 04, 2011	•			Administrator, D.O.N., A.D.C and QA).IN.,	
	Di vivivo Outon	. 1.4. 1 A			Committee***REVISIOND.O	.N is	
	Physician Orders dated August 11, 2011				now tracking U/A C&S daily		
	[time not docum	-			ensure all orders are followe	d in a	
	· ·	n antibiotic, for treatment			timely manner. She will repo		
		urinary tract infection			Administrator and A.D.O.N. i	n	
	had been implem	nented/started.			morning meeting on any discrepency in orders. All		
					discrepincies will be brought		
	Medication Adm	inistration Records dated			monthly QA meetings. Monit		
	August 01, 2011	through August 31, 2011;			by: Administrator, D.O.N.,		
	indicated Reside	nt E received the			A.D.O.N., and QA Committe	е	
	initial/first dose	of Nitroforantoin on					
	August 11, 2011						
	71ugust 11, 2011	at 0.00 p.m.					
	The facility's Del	licy and Procedure for					
	1	[non-dated] provided by					
	*						
		Jursing on August 30,					
	· ·	'Purpose: To ensure all					
	physician order's						
	followed through	n. Procedure: 1. A					
	duplicate copy of	f all new physician orders					
	obtained during	each shift will be attached					
	to the 24 hour re	port sheet. 2. All new					
		tote down on the 24 hour					
		. If there is no call back					
	_	abs the initial nurse to					
		shift to follow through					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155358	B. WIN	G		08/30/2	011
NAME OF P	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					OPLAR ST		
MEADOV	MEADOWS MANOR CONVALESCENT & REHAB CENTER			TERRE	HAUTE, IN47803		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		+	TAG	DEFICIENCY)		DATE
	The oncoming shift to follow up with call						
		till no return calls notify					
		Tursing, and/or Assistant					
		ing. The Medical					
		or of Nursing, and/or					
		or of Nursing will be					
	notified if no retu	urn call with in 24 hours.					
	5. Daily report	t sheets will be obtained					
	by an administra	tive nurse after morning					
	report to be reviewed for accuracy and						
	follow up as need	ded.					
	The Director of N	Nursing was interviewed					
	on August 29, 20	011 at 2:15 p.m. During					
	the interview the	Director of Nursing					
		nt E's physician received					
		Microbiology and					
		g results dated August					
		gust 11, 2011. The					
	physician should						
		e urinalysis results on					
		; to initiate prompt					
	_	diagnosed urinary tract					
	infection.	anagnosca armary tract					
	micenon.						
	This deficiency i	s related to Complaint					
	IN00095253.	s related to Complaint					
	111000/3233.						
	2.1.41(a)(2)						
	3.1-41(a)(2)						
EUZUZ	The facility must n	romptly notify the attending					
F0505 SS=D	physician of the fir						
JO 10	Based on interviews and record reviews		FO	505	Meadows Manor East does notify		09/16/2011
		to ensure an urinalysis			physicians of lab results on a		55,10,2011
	and radinity railed	. to thouse an armaryon					

li ´		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155358	A. BUI	LDING	00	08/30/2	
		155556	B. WIN			06/30/2	011
NAME OF	PROVIDER OR SUPPLIEF	3		1	ADDRESS, CITY, STATE, ZIP CODE		
MEADO	WS MANOR CONV	ALESCENT & REHAB CENTER		1	OPLAR ST HAUTE, IN47803		
				L	11/012, 11/4/7003		
(X4) ID		STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION DATE
1710	†	had been promptly	1	1710	timely basis. This F-tag is a	rare	DATE
	reported to a resi				occurrance for this facility, ar		
	1 *	· ·			occurred because a few nurs		
	1	of 3 residents reviewed for			did not follow the policy. Res		
	1	g of laboratory results in			E was monitored during the I time period, and showed no		
	a sample of 11 fe	esidents. (Resident E)			and symptoms of discomfort		
	F: 1: : 1 1				attached #'s 6 & 7). The U/A		
	Findings include): 			faxed timely, but the C & S h		
					be reincubated with results fa		
		nical records were			at a later date. The results w not reported to the D.O.N. or		
	reviewed on August 25, 2011 at 2:30 p.m.				physician as per policy. To		
	Physician's orders dated August 01, 2011				prevent this F-tag from		
					reoccurring to resident E and		
	•	icated for staff to obtain			other residents of this facility inservice was held on 9-15-1		
	· -	aboratory test for analysis					
	_	llture and sensitivity			reporting lab results to physic (see attached #5).Monitored		
	[susceptibility ar	nd/or resistance to			D.O.N., Administrator and Q		
	antibiotics of ide	entified microorganisms],			Committee***REVISIOND.O.N.	.N.	
	due to a possible	e diagnosis of an urinary			will monitor U/AC&S daily to monitor lab results and Dr.		
	tract infection.				notification. Labs not receive	d or	
					reported to physcians will be		
	Nurse's Notes in	dicated; "8-2-11 0530			immediately and reported to		
	[5:30 a.m.] UA [urinalysis] and C&S			Administrator daily and mont Q.A. commitee.Monitored by		
	[culture and sens	sitivity] obtained @ this			D.O.N., Administrator and Q.		
	time"				Committee		
	A Microbiology	and Molecular Testing					
	report dated Aug	gust 05, 2011 indicated;					
	"Source: Urine.	Collected: 08/02/11					
	05:30. Received	1: 08/02/11 15:21 [3:21					
	p.m.]. Urine wit	th Colony Count Culture -					
	Isolate: 01 Esch	erichia coli 100,000					
	CFU/mL [volum	ne of identified bacteria in					
	urine]. A list of	antibiotics the identified					
	bacteria is resista	ant to, was printed on the					

000249

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER: 155358	A. BUILDING 00		00	COMPLETED 08/30/2011		
100000			B. WIN			00/30/2	011	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
MEADO	NS MANOR CONVA	ALESCENT & REHAB CENTER	3300 POPLAR ST TERRE HAUTE, IN47803					
					11/101E, 114-7000		710	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	·	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG		CROSS-REFERENCED TO THE APPROPRIATE		
-	report.			_			DATE	
	тероп.							
	Continued review of Nurse's Notes							
	indicated on August 11, 2011 [time not							
	documented] Resident E's attending							
	physician had received the Microbiology and Molecular Testing report dated August 04, 2011. An antibiotic							
	[Nitroforantoin] for treatment of a							
	-	y tract infection had been						
	implemented/star	-						
	P							
	The facility's Pol	icy for Tracking Labs						
	Obtained and Lal	b Results dated January						
	14, 2007; provide	ed by the Director of						
	Nursing on Augu	st 29, 2011; indicated						
	"The following will be attached to the							
	daily report sheet by each charge nurse on							
	each shift: 1. A duplicate copy of all new							
	physician orders	obtained during each						
	shift. 2. A duplic	cate copy of labs obtained						
	during each shift. 3. The temporary copy							
	_	received during each						
		ning charge nurse will be						
		3. All labs obtained						
	_	hite copies) are to be						
	attached to daily	report sheet to ensure						
	that all labs are o	btained as ordered 4.						
	Lab results are to	have a copy of physician						
		tion attached and/or						
	written notification	on on the lab result sheet						
	that physician ha	s been notified. If no fax						
		written notification that						
	physician has been notified, the oncoming							

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENT		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155358	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMI 08/30/	E SURVEY PLETED 2011		
MEADO\		ALESCENT & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3300 POPLAR ST TERRE HAUTE, IN47803					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
	-	ble to see that the fied either by fax and/or						
	on August 29, 20 the interview the indicated Reside received the resu and Molecular To August 05, 2011 The physician sh notification of th August 05, 2011 facility's policy a	Nursing was interviewed Director of Nursing Int E's physician had Its of the Microbiology esting results dated c on August 11, 2011. ould have received e urinalysis results on c as indicated by the end procedure. Is related to Complaint						